Complete Summary

GUIDELINE TITLE

Practice guideline for the assessment and treatment of patients with suicidal behaviors.

BIBLIOGRAPHIC SOURCE(S)

American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Arlington (VA): American Psychiatric Association; 2003 Nov. 117 p. [846 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

On January 13, 2006, Novartis and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of revisions to the BOXED WARNING, WARNINGS, CONTRAINDICATIONS, PRECAUTIONS (Information for Patients and Pharmacokinetic-Related Interactions subsections), and ADVERSE REACTIONS (Postmarketing Clinical Experience subsection) sections of the prescribing information for Clozaril (clozapine) tablets. Recommendations from the FDA's Psychopharmacological Drugs Advisory Committee regarding the white blood cell monitoring schedule, required for all clozapine users, has resulted in modification in the monitoring schedule. Additional labeling changes address safety issues related to dementia-related psychosis, parlytic ileus, hypercholesterolemia and pharmacokinetic interaction with citalopram. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Suicidal ideation and behavior

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To assist psychiatrists in the assessment and care of their patients with suicidal ideation/behaviors
- To represent a synthesis of current scientific knowledge and clinical consensus

TARGET POPULATION

Adult patients with suicidal ideation and/or behaviors

INTERVENTIONS AND PRACTICES CONSIDERED

Suicide Assessment

1. Thorough psychiatric evaluation, including:
    - specific psychiatric signs and symptoms
    - psychiatric history, including current treatment
    - past suicidal or other self-injurious behaviors (including intent of such acts)
    - family history of suicide, mental illness, and dysfunction
    - current psychosocial situation and nature of crisis
2. Inquiry about suicidal thoughts, plans, and behaviors (elicit presence or absence of suicidal ideation, suicide plan, and the intent and lethality of any plans)

3. Suicide risk estimation to include, demographic factors, major psychiatric syndromes (primary and co-morbid conditions), specific psychiatric symptoms, other aspects of psychiatric history, physical illness, family history, psychosocial factors, and degree of suicidality, as well as, consideration of modifiable and protective factors

Psychiatric Management

1. Attending to the patient's safety
2. Establishing and maintaining a therapeutic alliance
3. Determining a treatment setting (e.g., involuntary hospitalization, partial hospital and intensive outpatient programs, ambulatory settings)
4. Developing a plan of treatment
5. Coordinating care and collaborating with other clinicians
6. Promoting adherence to the treatment plan
7. Providing education to the patient and family
8. Reassessing safety and suicide risk (suicide crisis and chronic suicidality)
9. Monitoring psychiatric status and response to treatment
10. Obtaining consultation, if indicated

Specific Treatments

1. Antidepressants
    - Serotonin reuptake inhibitors (SRIs)
    - Tricyclic antidepressants (TCAs)
    - Monoamine oxidase inhibitors (MAOIs)
2. Lithium
3. Anticonvulsants
4. Antipsychotics
    - Clozapine
    - Other second-generation antipsychotic agents (e.g., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole)
5. Anti-anxiety agents
    - Benzodiazepines
6. Electroconvulsive therapy (ECT)
7. Psychosocial interventions including psychotherapy

Documentation and Risk Management

1. Documentation issues specific to suicide
2. Suicide prevention contracts: limitations and clinical use
3. Management of a suicide in one's practice
4. Mental health interventions for surviving family and friends after a suicide

MAJOR OUTCOMES CONSIDERED

- Morbidity and mortality
- Severity of symptoms
- Rate of remission, relapse, and recurrence of suicidality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Relevant literature was identified through a computerized search of PubMed for the period from 1966 to 2002. Key words used were "suicides," "suicide," "attempted suicide," "attempted suicides," "parasuicide," "parasuicides," "self-harm," "self-harming," "suicide, attempted," "suicidal attempt," and "suicidal attempts." A total of 34,851 citations were found. After limiting these references to literature published in English that included abstracts, 17,589 articles were screened by using title and abstract information. Additional, less formal literature searches were conducted by American Psychiatric Association (APA) staff and individual members of the work group on suicidal behaviors through the use of PubMed, PsycINFO, and Social Sciences Citation Index. Sources of funding were not considered when reviewing the literature.

NUMBER OF SOURCE DOCUMENTS

34,851 citations
17,589 articles

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and clinical experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstances

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline development process involved the production of multiple drafts with widespread review, in which six organizations and over 60 individuals submitted comments and approval by the American Psychiatric Association Assembly and Board of Trustees.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation.

Definition of grades of recommendation [I-III] are presented at the end of the "Major Recommendations" field.

Suicide Assessment

The psychiatric evaluation is the essential element of the suicide assessment process [I]. During the evaluation, the psychiatrist obtains information about the patient's psychiatric and other medical history and current mental state (e.g., through direct questioning and observation about suicidal thinking and behavior as well as through collateral history, if indicated). This information enables the psychiatrist to 1) identify specific factors, signs, and symptoms that may generally increase or decrease risk for suicide or other suicidal behaviors and that may serve as modifiable targets for both acute and ongoing interventions, 2) address the patient's immediate safety and determine the most appropriate setting for treatment, and 3) develop a multiaxial differential diagnosis to further guide planning of treatment. The breadth and depth of the psychiatric evaluation aimed specifically at assessing suicide risk will vary with setting; ability or willingness of the patient to provide information; and availability of information from previous contacts with the patient or from other sources, including other mental health professionals, medical records, and family members. Although suicide assessment scales have been developed for research purposes, they lack the predictive validity necessary for use in routine clinical practice. Therefore, suicide assessment scales may be used as aids to suicide assessment but should not be used as predictive instruments or as substitutes for a thorough clinical evaluation [I].

Table 1 of the original guideline document presents the important domains of a suicide assessment, including the patient's current presentation, individual strengths and weaknesses, history, and psychosocial situation. Information may come from the patient directly or from other sources, including family members, friends, and others in the patient's support network, such as community residence staff or members of the patient´s military command. Such individuals may be able to provide information about the patient´s current mental state, activities, and psychosocial crises and may also have observed behavior or been privy to communications from the patient that suggest suicidal ideation, plans, or intentions. Contact with such individuals may also provide opportunity for the psychiatrist to attempt to fortify the patient´s social support network. This goal often can be accomplished without the psychiatrist´s revealing private or confidential information about the patient. In clinical circumstances in which sharing information is important to maintain the safety of the patient or others, it is permissible and even critical to share such information without the patient's consent [I].

When communicating with the patient, it is important to remember that simply asking about suicidal ideation does not ensure that accurate or complete information will be received. Cultural or religious beliefs about death or suicide, for example, may influence a patient's willingness to speak about suicide during the assessment process as well as the patient's likelihood of acting on suicidal ideas. Consequently, the psychiatrist may wish to explore the patient's cultural and religious beliefs, particularly as they relate to death and to suicide [II].

It is important for the psychiatrist to focus on the nature, frequency, depth, timing, and persistence of suicidal ideation [I]. If ideation is present, request more detail about the presence or absence of specific plans for suicide, including any steps taken to enact plans or prepare for death [I]. If other aspects of the clinical presentation seem inconsistent with an initial denial of suicidal thoughts, additional questioning of the patient may be indicated [II].

Where there is a history of suicide attempts, aborted attempts, or other self-harming behavior, it is important to obtain as much detail as possible about the timing, intent, method, and consequences of such behaviors [I]. It is also useful to determine the life context in which they occurred and whether they occurred in association with intoxication or chronic use of alcohol or other substances [II]. For individuals in previous or current psychiatric treatment, it is helpful to determine the strength and stability of the therapeutic relationship(s) [II].

If the patient reports a specific method for suicide, it is important for the psychiatrist to ascertain the patient's expectation about its lethality, for if actual lethality exceeds what is expected, the patient's risk for accidental suicide may be high even if intent is low [I]. In general, the psychiatrist should assign a higher level of risk to patients who have high degrees of suicidal intent or describe more detailed and specific suicide plans, particularly those involving violent and irreversible methods [I]. If the patient has access to a firearm, the psychiatrist is advised to discuss with and recommend to the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons [I].

Documenting the suicide assessment is essential [I]. Typically, suicide assessment and its documentation occur after an initial evaluation or, for patients in ongoing treatment, when suicidal ideation or behaviors emerge or when there is significant worsening or dramatic and unanticipated improvement in the patient's condition. For inpatients, reevaluation also typically occurs with changes in the level of precautions or observations, when passes are issued, and during evaluation for discharge. As with the level of detail of the suicide assessment, the extent of documentation at each of these times varies with the clinical circumstances. Communications with other caregivers and with the family or significant others should also be documented [I]. When the patient or others have been given specific instructions about firearms or other weapons, this communication should also be noted in the record [I].

Estimation of Suicide Risk

The statistical rarity of suicide also makes it impossible to predict on the basis of risk factors either alone or in combination. For the psychiatrist, knowing that a particular factor (e.g., major depressive disorder, hopelessness, substance use) increases a patient's relative risk for suicide may affect the treatment plan, including determination of a treatment setting. At the same time, knowledge of risk factors will not permit the psychiatrist to predict when or if a specific patient will die by suicide. This does not mean that the psychiatrist should ignore risk factors or view suicidal patients as untreatable. On the contrary, an initial goal of the psychiatrist should be to estimate the patient's risk through knowledgeable assessment of risk and protective factors, with a primary and ongoing goal of reducing suicide risk [I].

Some factors may increase or decrease risk for suicide; others may be more relevant to risk for suicide attempts or other self-injurious behaviors, which are in turn associated with potential morbidity as well as increased suicide risk. In weighing risk and protective factors for an individual patient, consideration may be given to 1) the presence of psychiatric illness; 2) specific psychiatric symptoms such as hopelessness, anxiety, agitation, or intense suicidal ideation; 3) unique circumstances such as psychosocial stressors and availability of methods; and 4) other relevant clinical factors such as genetics and medical, psychological, or psychodynamic issues [I].

Once suicide risk and protective factors are identified, the psychiatrist can determine if these factors are modifiable. Past history, family history, and demographic characteristics are examples of nonmodifiable factors. Financial difficulties or unemployment can also be difficult to modify, at least in the short term. While immutable factors are important to identify, they cannot be the focus of intervention. Rather, to decrease a patient's suicide risk, the treatment should attempt to mitigate or strengthen those risk and protective factors that can be modified [I]. For example, the psychiatrist may attend to patient safety, address associated psychological or social problems and stressors, augment social support networks, and treat associated psychiatric disorders (such as mood disorders, psychotic disorders, substance use disorders, and personality disorders) or symptoms (such as severe anxiety, agitation, or insomnia).

Psychiatric Management

Psychiatric management consists of a broad array of therapeutic interventions that should be instituted for patients with suicidal thoughts, plans, or behaviors [I]. Psychiatric management includes attending to patient safety, determining a setting for treatment and supervision, and working to establish a cooperative and collaborative physician-patient relationship. For patients in ongoing treatment, psychiatric management also includes establishing and maintaining a therapeutic alliance; coordinating treatment provided by multiple clinicians; monitoring the patient´s progress and response to the treatment plan; and conducting ongoing assessments of the patient's safety, psychiatric status, and level of functioning. Additionally, psychiatric management may include encouraging treatment adherence and providing education to the patient and, when indicated, family members and significant others.

Patients with suicidal thoughts, plans, or behaviors should generally be treated in the setting that is least restrictive yet most likely to be safe and effective [I]. Treatment settings and conditions include a continuum of possible levels of care, from involuntary inpatient hospitalization through partial hospital and intensive outpatient programs to occasional ambulatory visits. Choice of specific treatment setting depends not only on the psychiatrist's estimate of the patient's current suicide risk and potential for dangerousness to others, but also on other aspects of the patient's current status, including 1) medical and psychiatric comorbidity; 2) strength and availability of a psychosocial support network; and 3) ability to provide adequate self-care, give reliable feedback to the psychiatrist, and cooperate with treatment. In addition, the benefits of intensive interventions such as hospitalization must be weighed against their possible negative effects (e.g., disruption of employment, financial and other psychosocial stress, social stigma).

For some individuals, self-injurious behaviors may occur on a recurring or even chronic basis. Although such behaviors may occur without evidence of suicidal intent, this may not always be the case. Even when individuals have had repeated contacts with the health care system for self-injurious behavior, each act should be reassessed in the context of the current situation [I].

In treating suicidal patients, particularly those with severe or recurring suicidality or self-injurious behavior, the psychiatrist should be aware of his or her own emotions and reactions that may interfere with the patient's care [I]. For difficult-to-treat patients, consultation or supervision from a colleague may help in affirming the appropriateness of the treatment plan, suggesting alternative therapeutic approaches, or monitoring and dealing with countertransference issues [I].

The suicide prevention contract, or "no-harm contract," is commonly used in clinical practice but should not be considered as a substitute for a careful clinical assessment [I]. A patient's willingness (or reluctance) to enter into an oral or a written suicide prevention contract should not be viewed as an absolute indicator of suitability for discharge (or hospitalization) [I]. In addition, such contracts are not recommended for use with patients who are agitated, psychotic, impulsive, or under the influence of an intoxicating substance [II]. Furthermore, since suicide prevention contracts are dependent on an established physician-patient relationship, they are not recommended for use in emergency settings or with newly admitted or unknown inpatients [II].

Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice. When the suicide of a patient occurs, the psychiatrist may find it helpful to seek support from colleagues and obtain consultation or supervision to enable him or her to continue to treat other patients effectively and respond to the inquiries or mental health needs of survivors [II]. Consultation with an attorney or a risk manager may also be useful [II]. The psychiatrist should be aware that patient confidentiality extends beyond the patient's death and that the usual provisions relating to medical records still apply. Any additional documentation included in the medical record after the patient's death should be dated contemporaneously, not backdated, and previous entries should not be altered [I]. Depending on the circumstances, conversations with family members may be appropriate and can allay grief [II]. In the aftermath of a loved one's suicide, family members themselves are more vulnerable to physical and psychological disorders and should be helped to obtain psychiatric intervention, although not necessarily by the same psychiatrist who treated the individual who died by suicide [II].

Specific Treatment Modalities

In developing a plan of treatment that addresses suicidal thoughts or behaviors, the psychiatrist should consider the potential benefits of somatic therapies as well as the potential benefits of psychosocial interventions, including the psychotherapies [I]. Clinical experience indicates that many patients with suicidal thoughts, plans, or behaviors will benefit most from a combination of these treatments [II]. The psychiatrist should address the modifiable risk factors identified in the initial psychiatric evaluation and make ongoing assessments during the course of treatment [I]. In general, therapeutic approaches should

target specific axis I and axis II psychiatric disorders; specific associated symptoms such as depression, agitation, anxiety, or insomnia; or the predominant psychodynamic or psychosocial stressor [I] While the goal of pharmacologic treatment may be acute symptom relief, including acute relief of suicidality or acute treatment of a specific diagnosis, the treatment goals of psychosocial interventions may be broader and longer term, including achieving improvements in interpersonal relationships, coping skills, psychosocial functioning, and management of affects. Since treatment should be a collaborative process between the patient and clinician(s), the patient´s preferences are important to consider when developing an individual treatment plan [I].

Somatic Interventions

Evidence for a lowering of suicide rates with antidepressant treatment is inconclusive. However, the documented efficacy of antidepressants in treating acute depressive episodes and their long-term benefit in patients with recurrent forms of severe anxiety or depressive disorders support their use in individuals with these disorders who are experiencing suicidal thoughts or behaviors [II]. It is advisable to select an antidepressant with a low risk of lethality on acute overdose, such as a selective serotonin reuptake inhibitor (SSRI) or other newer antidepressant, and to prescribe conservative quantities, especially for patients who are not well-known [I]. For patients with prominent insomnia, a sedating antidepressant or an adjunctive hypnotic agent can be considered [II]. Since antidepressant effects may not be observed for days to weeks after treatment has started, patients should be monitored closely early in treatment and educated about this probable delay in symptom relief [I].

To treat symptoms such as severe insomnia, agitation, panic attacks, or psychic anxiety, benzodiazepines may be indicated on a short-term basis [II], with long-acting agents often being preferred over short-acting agents [II]. The benefits of benzodiazepine treatment should be weighed against their occasional tendency to produce disinhibition and their potential for interactions with other sedatives, including alcohol [I]. Alternatively, other medications that may be used for their calming effects in highly anxious and agitated patients include trazodone, low doses of some second-generation antipsychotics, and some anticonvulsants such as gabapentin or divalproex [III]. If benzodiazepines are being discontinued after prolonged use, their doses should be reduced gradually and the patient monitored for increasing symptoms of anxiety, agitation, depression, or suicidality [II].

There is strong evidence that long-term maintenance treatment with lithium salts is associated with major reductions in the risk of both suicide and suicide attempts in patients with bipolar disorder, and there is moderate evidence for similar risk reductions in patients with recurrent major depressive disorder [I]. Specific anticonvulsants have been shown to be efficacious in treating episodes of mania (i.e., divalproex) or bipolar depression (i.e., lamotrigine), but there is no clear evidence that their use alters rates of suicide or suicidal behaviors [II]. Consequently, when deciding between lithium and other first-line agents for treatment of patients with bipolar disorder, the efficacy of lithium in decreasing suicidal behavior should be taken into consideration when weighing the benefits and risks of treatment with each medication. In addition, if lithium is prescribed,

the potential toxicity of lithium in overdose should be taken into consideration when deciding on the quantity of lithium to give with each prescription [I].

Clozapine treatment is associated with significant decreases in rates of suicide attempts and perhaps suicide for individuals with schizophrenia and schizoaffective disorder. Thus, clozapine treatment should be given serious consideration for psychotic patients with frequent suicidal ideation, attempts, or both [I]. If treatment is indicated with an antipsychotic other than clozapine, the other second-generation antipsychotics (e.g., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole) are preferred over the first-generation antipsychotic agents [I].

Electroconvulsive therapy (ECT) has established efficacy in patients with severe depressive illness, with or without psychotic features. Since ECT is associated with a rapid and robust antidepressant response as well as a rapid diminution in associated suicidal thoughts, ECT may be recommended as a treatment for severe episodes of major depression that are accompanied by suicidal thoughts or behaviors [I]. Under certain clinical circumstances, ECT may also be used to treat suicidal patients with schizophrenia, schizoaffective disorder, or mixed or manic episodes of bipolar disorder [II]. Regardless of diagnosis, ECT is especially indicated for patients with catatonic features or for whom a delay in treatment response is considered life threatening [I]. ECT may also be indicated for suicidal individuals during pregnancy and for those who have already failed to tolerate or respond to trials of medication [II]. Since there is no evidence of a long-term reduction of suicide risk with ECT, continuation or maintenance treatment with pharmacotherapy or with ECT is recommended after an acute ECT course [I].

Psychosocial Interventions

Psychotherapies and other psychosocial interventions play an important role in the treatment of individuals with suicidal thoughts and behaviors [II]. A substantial body of evidence supports the efficacy of psychotherapy in the treatment of specific disorders, such as nonpsychotic major depressive disorder and borderline personality disorder, which are associated with increased suicide risk. For example, interpersonal psychotherapy and cognitive behavior therapy have been found to be effective in clinical trials for the treatment of depression. Therefore, psychotherapies such as interpersonal psychotherapy and cognitive behavior therapy may be considered appropriate treatments for suicidal behavior, particularly when it occurs in the context of depression [II]. In addition, cognitive behavior therapy may be used to decrease two important risk factors for suicide: hopelessness [II] and suicide attempts in depressed outpatients [III]. For patients with a diagnosis of borderline personality disorder, psychodynamic therapy and dialectical behavior therapy may be appropriate treatments for suicidal behaviors [II], because modest evidence has shown these therapies to be associated with decreased self-injurious behaviors, including suicide attempts. Although not targeted specifically to suicide or suicidal behaviors, other psychosocial treatments may also be helpful in reducing symptoms and improving functioning in individuals with psychotic disorders and in treating alcohol and other substance use disorders that are themselves associated with increased rates of suicide and suicidal behaviors [II]. For patients who have attempted suicide or engaged in self-harming behaviors without suicidal intent, specific psychosocial interventions such as rapid intervention; follow-up outreach; problem-solving

therapy; brief psychological treatment; or family, couples, or group therapies may be useful despite limited evidence for their efficacy [III].

Definitions:

Each recommendation is identified at falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstances

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on the best available data and clinical consensus with regard to a particular clinical decision. The summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made (see the "Major Recommendations" field). In addition, the following coding system is used to indicate the nature of the supporting evidence in the references:

[A] Randomized, double blind clinical trial A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are "blind" to the assignments

[A--] Randomized clinical trial Same as above but not double blind

[B] Clinical trial A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial

[C] Cohort or longitudinal study A study in which subjects are prospectively followed over time without any specific intervention

[D] Case-control study A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time

[E] Review of secondary analysis A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis

[F] Review A qualitative review and discussion of previously published literature without a quantitative synthesis of the data

[G] Other Textbooks, expert opinion, case reports, and other reports not included above

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Increased understanding of suicide risk and intervention by psychiatric professionals
- Decreased rates of suicide
- Decreased rates of suicide attempts
- Improved control of symptoms related to suicidal ideation and behaviors

Refer to the original guideline document for the evidence synthesis related to specific interventions.

POTENTIAL HARMS

See the original guideline document for discussion of some of the side effects associated with drugs used to manage individuals with suicidal ideation and behavior.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This practice guideline is based on available evidence and clinical consensus and offers recommendations to help psychiatrists in assessing and treating adult patients with suicidal behaviors. This report is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.
- This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments

discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of the American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

- This document represents a synthesis of current scientific knowledge and rational clinical practice on the assessment and treatment of adult patients with suicidal behaviors. It strives to be as free as possible of bias toward any theoretical approach to treatment. In order for the reader to appreciate the evidence base behind the guideline recommendations and the weight that should be given to each recommendation, the summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made. Each rating of clinical confidence considers the strength of the available evidence and is based on the best available data. When evidence is limited, the level of confidence also incorporates clinical consensus with regard to a particular clinical decision. In the listing of cited references, each reference is followed by a letter code in brackets that indicates the nature of the supporting evidence.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Psychiatric Association. Practice guideline for the assessment and treatment of patients with suicidal behaviors. Arlington (VA): American Psychiatric Association; 2003 Nov. 117 p. [846 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 Nov

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

GUIDELINE COMMITTEE

Work Group on Suicidal Behaviors

Steering Committee on Practice Guidelines

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of the American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American Psychiatric Association's Web site.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- American Psychiatric Association practice guideline development process. In: practice guidelines for the treatment of psychiatric disorders: compendium 2000. Washington (DC): American Psychiatric Press, Inc (APPI), 2000.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

Additionally, a continuing medical education (CME) course is available online at the American Psychiatric Association Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 19, 2004. The information was verified by the guideline developer on June 29, 2004. This summary was updated by ECRI on January 18, 2006, following the U.S. Food and Drug Administration advisory on Clozaril (clozapine).

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DISCLAIMER

NGC DISCLAIMER

Date Modified: 9/25/2006